Senate

General Assembly

File No. 226

January Session, 2011

Senate Bill No. 1083

Senate, March 28, 2011

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT CONCERNING HEALTH INSURANCE COVERAGE OF PRESCRIPTION DRUGS FOR PAIN TREATMENT.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-492i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**on or after January 1, 2001,**]** shall provide access to a pain management specialist and coverage for pain treatment ordered by such specialist **[**which**]** that may include all means medically necessary to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures.

(b) (1) No such policy that provides coverage for prescription drugs shall require an insured to use, prior to using a brand name

prescription drug prescribed by a licensed physician for pain treatment, any alternative brand name prescription drugs or over-the-counter drugs.

(2) Such policy may require an insured to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, a therapeutically equivalent generic drug.

(c) As used in this section, "pain" means a sensation in which a person experiences severe discomfort, distress or suffering due to provocation of sensory nerves, and "pain management specialist" means a physician who is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, neurologist, oncologist or radiation oncologist with additional training in pain management.

Sec. 2. Section 38a-518i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2012*):

(a) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state **[**on or after January 1, 2001,**]** shall provide access to a pain management specialist and coverage for pain treatment ordered by such specialist **[**which**]** that may include all means medically necessary to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures.

(b) (1) No such policy that provides coverage for prescription drugs shall require an insured to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, any alternative brand name prescription drugs or over-the-counter drugs.

(2) Such policy may require an insured to use, prior to using a brand name prescription drug prescribed by a licensed physician for pain treatment, a therapeutically equivalent generic drug.

(c) As used in this section, "pain" means a sensation in which a person experiences severe discomfort, distress or suffering due to provocation of sensory nerves, and "pain management specialist" means a physician who is credentialed by the American Academy of Pain Management or who is a board-certified anesthesiologist, neurologist, oncologist or radiation oncologist with additional training in pain management.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2012*	38a-492i
Sec. 2	*January 1, 2012*	38a-518i

INS *Joint Favorable*

OFA Fiscal Note

State Impact: None , See below for the out years impact

Municipal Impact:

Municipalities	Effect	FY 12 $	FY 13 $
Various Municipalities	STATE MANDATE - Cost	Potential	Potential

Explanation

The bill's provisions do not result in a fiscal impact to the state. The state employee health plan currently permits patients to fill prescriptions as prescribed by their treating physician. A prior authorization may be required by the treating physician for some drugs, which is not prohibited by the bill. Secondly, the state plan does not require step-therapy for pain management. Lastly, the state plan currently requires mandatory generic substitution, which is not prohibited by the bill.

The bill's provisions may increase costs to certain fully insured municipal plans that currently require alternative brand-name prescriptions or step-therapy for the treatment of pain. The coverage requirements may result in increased premium costs when municipalities enter into new health or prescription drug coverage contracts after January 1, 2012. Due to federal law, municipalities with self-insured health plans are exempt from state health insurance benefit mandates.

Many municipal health plans are recognized as "grandfathered" health plans under the Patient Protection and Affordability Care Act

(PPACA)[1]. It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans PPACA[2].

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

The federal health care reform act requires that, effective January 1, 2014; all states must establish a health benefit exchange, which will offer qualified plans that must include a federally defined essential benefits package. While states are allowed to mandate benefits in excess of the basic package, the federal law appears to require the state to pay the cost of any such additional mandated benefits. The extent of these costs will depend on the mandates included in the federal essential benefit package, which have not yet been determined. However, neither the agency nor mechanism for the state to pay these costs has been established.

[1] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010. Pursuant to the PPACA, all health plans, including those with grandfathered status are required to provide the following as of September 23, 2010: 1) No lifetime limits on coverage, 2) No rescissions of coverage when individual gets sick or has previously made an unintentional error on an application, and 3) Extension of parents' coverage to young adults until age 26. (www.healthcare.gov)

[2] According to the PPACA, compared to the plans' policies as of March 23, 2010, grandfathered plans who make any of the following changes within a certain margin may lose their grandfathered status: 1) Significantly cut or reduce benefits, 2) Raise co-insurance charges, 3) Significantly raise co-payment charges, 4) Significantly raise deductibles, 5) Significantly lower employer contributions, and 5) Add or tighten annual limits on what insurer pays. (www.healthcare.gov)

OLR Bill Analysis

SB 1083

AN ACT CONCERNING HEALTH INSURANCE COVERAGE OF PRESCRIPTION DRUGS FOR PAIN TREATMENT.

SUMMARY:

This bill prohibits certain individual and group health policies that provide prescription drug coverage from requiring an insured to use an alternative brand name prescription drug or over-the-counter drug before using a brand name prescription drug prescribed by a licensed physician for pain treatment. But, it allows these policies to require an insured to first use a therapeutically equivalent generic drug.

The bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; (4) hospital or medical services, including coverage under an HMO plan; and (5) limited benefits.

Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2012

BACKGROUND

Related Bills

SB 13, (File 10) favorably reported by the Insurance and Real Estate Committee prohibits certain health insurance policies and medical contracts from imposing payment provisions or conditions (e.g., copayment, reimbursement amount, number of doses) for prescriptions obtained from a retail pharmacy that are more restrictive than those imposed for prescriptions obtained from a mail order

pharmacy.

SB 153, favorably reported by the Insurance and Real Estate Committee, allows an insured to obtain a prescription drug refill up to two business days before the date it is authorized to be refilled.

SB 1084, favorably reported by the Insurance and Real Estate Committee, prohibits certain individual and group health policies that provide prescription drug benefits from imposing a coinsurance, copayment, deductible, or other out-of-pocket expense for nonpreferred brand named drugs that place a greater financial burden on an insured than for preferred brand name drugs.

HB 5439, favorably reported by the Insurance and Real Estate Committee, establishes a task force to study prescription drug coverage insurance plans available to state residents.

HB 6349 (File 102), prohibits certain health insurers that provide prescription drug coverage from denying coverage for the refilling of any drug prescribed to treat a chronic illness if the refill is made in accordance with a plan to synchronize the refilling of multiple prescriptions.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 14 Nay 6 (03/15/2011)